

	CareConnect Tradition Platinum 30/30		CareConnect Standard Platinum		CareConnect Value Platinum		CareConnect Tradition Gold 30/50	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	15/35/75/100 ded T2-3		10/30/60		0/50/50%to\$500		15/35/75/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		N/A		\$1,000/\$2,000	
Individual/Family OOP Limit	\$1,000/\$2,000		\$2,000/\$4,000		\$3,000/\$6,000		\$3,000/\$6,000 (incl ded)	
Co-Insurance	0%		0%		10%		10%	
Office Visits								
Primary Care	\$30		\$15		\$20		\$30 ded waived	
Specialist	\$30		\$35		\$30		\$50 ded waived	
Inpatient Services								
Inpatient Hospital	\$500/admit		\$500/admit		10%		10% after ded	
Mental Health Inpatient	\$500/admit		\$500/admit		10%		10% after ded	
Outpatient Services								
Outpatient Facility	\$200		\$100		10%		10% after ded	
Lab/X-Ray	\$30		\$35		Lab-No charge; X-ray-\$40		10% after ded	
Mental Health Outpatient	\$30		\$15		No charge		\$30 ded waived	
Emergency Care								
Emergency Room	\$200 (waived if admitted)		\$100 (waived if admitted)		\$250 (waived if admitted)		\$200 (waived if admitted) ded waived	
Urgent Care	\$30		\$55		\$75		\$50 ded waived	
Single	1 x \$790.00		1 x \$780.00		1 x \$753.00		1 x \$696.00	
EE with Spouse	0 x \$1,580.00		0 x \$1,560.00		0 x \$1,506.00		0 x \$1,392.00	
EE with Child(ren)	0 x \$1,343.00		0 x \$1,326.00		0 x \$1,280.00		0 x \$1,183.00	
Family	1 x \$2,252.00		1 x \$2,223.00		1 x \$2,146.00		1 x \$1,984.00	
Monthly Cost	2 \$3,042.00		2 \$3,003.00		2 \$2,899.00		2 \$2,680.00	
Annual Cost	\$36,504.00		\$36,036.00		\$34,788.00		\$32,160.00	

	CareConnect Tradition Gold 40/60		CareConnect Standard Gold		CareConnect Tradition Gold Copay		CareConnect Value Gold 20/50	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	15/35/75/100 ded T2-3		10/35/70		15/35/75/100 ded T2-3		0/50/50%to\$500 IntDed T3	
Cost Share Information								
Individual/Family Deductible	N/A		\$600/\$1,200		N/A		\$500/\$1,000	
Individual/Family OOP Limit	\$7,150/\$14,300		\$4,000/\$8,000 (incl ded)		\$7,150/\$14,300		\$3,750/\$7,500 (incl ded)	
Co-Insurance	0%		0%		0%		20%	
Office Visits								
Primary Care	\$40		\$25 after ded		\$30		\$20 ded waived	
Specialist	\$60		\$40 after ded		\$50		\$50 ded waived	
Inpatient Services								
Inpatient Hospital	\$1,500/admit		\$1,000/admit after ded		\$500/day; \$1,500 max/admit		20% after ded	
Mental Health Inpatient	\$1,500/admit		\$1,000/admit after ded		\$500/day; \$1,500 max/admit		20% after ded	
Outpatient Services								
Outpatient Facility	\$300		\$100 after ded		\$300		20% after ded	
Lab/X-Ray	Lab-\$60; X-ray-\$40		\$40 after ded		\$30		Lab-\$40 ded waived; X-ray-\$60 ded waived	
Mental Health Outpatient	\$40		\$25 after ded		\$30		No charge	
Emergency Care								
Emergency Room	25%		\$150 (waived if admitted) after ded		\$350 (waived if admitted)		\$250 (waived if admitted) ded waived	
Urgent Care	\$60		\$60 after ded		\$50		\$75 ded waived	
Single	1 x \$681.00		1 x \$673.00		1 x \$663.00		1 x \$640.00	
EE with Spouse	0 x \$1,362.00		0 x \$1,346.00		0 x \$1,326.00		0 x \$1,280.00	
EE with Child(ren)	0 x \$1,158.00		0 x \$1,144.00		0 x \$1,127.00		0 x \$1,088.00	
Family	1 x \$1,941.00		1 x \$1,918.00		1 x \$1,890.00		1 x \$1,824.00	
Monthly Cost	2 \$2,622.00		2 \$2,591.00		2 \$2,553.00		2 \$2,464.00	
Annual Cost	\$31,464.00		\$31,092.00		\$30,636.00		\$29,568.00	

	CareConnect Value Gold 45/45		CareConnect Standard Silver		CareConnect Silver HSA 100%		CareConnect Value Silver	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	0/50/50%to\$500 IntDed T3		10/35/70		0%/0%/0% IntDed		0/50/50%to\$500 IntDed T3	
Cost Share Information								
Individual/Family Deductible	\$1,000/\$2,000		\$2,000/\$4,000		\$3,600/\$7,200		\$2,500/\$5,000	
Individual/Family OOP Limit	\$6,000/\$12,000 (incl ded)		\$6,750/\$13,500 (incl ded)		\$3,600/\$7,200 (incl ded)		\$7,100/\$14,200 (incl ded)	
Co-Insurance	10%		0%		0%		20%	
Office Visits								
Primary Care	\$45 ded waived		\$30 after ded		0% after ded		\$35 ded waived	
Specialist	\$45 ded waived		\$50 after ded		0% after ded		\$65 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		\$1,500/admit after ded		0% after ded		20% after ded	
Mental Health Inpatient	10% after ded		\$1,500/admit after ded		0% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	\$250 after ded		\$100 after ded		0% after ded		20% after ded	
Lab/X-Ray	Lab-No charge; X-ray-\$90 ded waived		\$50 after ded		0% after ded		\$75 ded waived	
Mental Health Outpatient	No charge		\$30 after ded		0% after ded		No charge	
Emergency Care								
Emergency Room	\$250 (waived if admitted) ded waived		\$250 (waived if admitted) after ded		0% after ded		\$250 (waived if admitted) after ded	
Urgent Care	\$75 ded waived		\$70 after ded		0% after ded		\$75 ded waived	
Single	1 x \$640.00		1 x \$590.00		1 x \$578.00		1 x \$569.00	
EE with Spouse	0 x \$1,280.00		0 x \$1,180.00		0 x \$1,156.00		0 x \$1,138.00	
EE with Child(ren)	0 x \$1,088.00		0 x \$1,003.00		0 x \$983.00		0 x \$967.00	
Family	1 x \$1,824.00		1 x \$1,682.00		1 x \$1,647.00		1 x \$1,622.00	
Monthly Cost	2 \$2,464.00		2 \$2,272.00		2 \$2,225.00		2 \$2,191.00	
Annual Cost	\$29,568.00		\$27,264.00		\$26,700.00		\$26,292.00	

Prepared For: **CareConnect 2017 4th qtr**

Nassau County, NY 11001

Prepared By: Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (4L)

Effective Date: 10/01/2017

Prepared On: 08/02/2017

Report ID: 33265348

SIC: 0000

	CareConnect Standard Bronze		CareConnect Bronze HSA 100%	
	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs				
Drug Card	10/35/70 IntDed		0%/0%/0% IntDed	
Cost Share Information				
Individual/Family Deductible	\$4,000/\$8,000		\$6,350/\$12,700	
Individual/Family OOP Limit	\$7,150/\$14,300 (incl ded)		\$6,350/\$12,700 (incl ded)	
Co-Insurance	50%		0%	
Office Visits				
Primary Care	50% after ded		0% after ded	
Specialist	50% after ded		0% after ded	
Inpatient Services				
Inpatient Hospital	50% after ded		0% after ded	
Mental Health Inpatient	50% after ded		0% after ded	
Outpatient Services				
Outpatient Facility	50% after ded		0% after ded	
Lab/X-Ray	50% after ded		0% after ded	
Mental Health Outpatient	50% after ded		0% after ded	
Emergency Care				
Emergency Room	50% after ded		0% after ded	
Urgent Care	50% after ded		0% after ded	
Single	1 x \$495.00		1 x \$482.00	
EE with Spouse	0 x \$990.00		0 x \$964.00	
EE with Child(ren)	0 x \$842.00		0 x \$819.00	
Family	1 x \$1,411.00		1 x \$1,374.00	
Monthly Cost	2 \$1,906.00		2 \$1,856.00	
Annual Cost	\$22,872.00		\$22,272.00	